

## EXHIBIT E

NOV 29 '01 09:29 FR

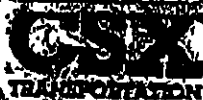
00/47/2001 06:08 318-2456359

904 359 3175 TO 82456675

P.01/03

DE OFFICE

PAGE 81



## EMPLOYEE'S INCIDENT REPORT

JUN 01/01  
FORM PH-1A ARJ  
REV 0/99

## INSTRUCTIONS FOR FORM PH-1A

1. This report will be completed by the employee as soon as possible after an accident/incident. If the employee is unable to complete this form, it may be typed or written by another employee; the employee must initial each answer entered in this manner.
2. Completed Form PH-1A RPN will be furnished to the employee's supervisor who, after review of the report and seeing that it is complete and signed, will fax and then mail the original to the reporting office in Jacksonville.
3. Supervisor will furnish the claims representative, in whose area of responsibility the accident/incident occurred, a copy of this report.

|  |  |  |  |  |  |   |  |
|--|--|--|--|--|--|---|--|
| INCIDENT NUMBER<br>01 [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]  |  | EMPLOYEE NAME<br>02 PAUL T. PAPADAKIS  |  | ID NUMBER<br>03 788224                               |  | SOCIAL SECURITY NO.<br>04 023384947     |  |
| ADDRESS<br>05 54 CARMEL LANE   |  | CITY<br>06 FEEDING HILLS               |  | STATE<br>07 MA.                                      |  | ZIP<br>08 01030                         |  |
| DATE OF BIRTH<br>09 02/14/48   |  | OCCUPATION<br>10 T-R FOREMAN           |  | DEPARTMENT<br>11 MW                                  |  | SUPERVISOR<br>12 R. ROSS                |  |
| DAYS WORKED<br>13 10   |  | NUMBER CONSECUTIVE DAYS WORKED<br>14 3 |  | NUMBER OF HOURS OFF PRIOR TO TOUR OF DUTY<br>15 15.2 |  | [ ]                                     |  |
| INCIDENT LOCATION<br>16 WEST WARREN  |  | INCIDENT CITY<br>17 WEST WARREN        |  | INCIDENT COUNTY<br>18 WORCESTER                      |  | INCIDENT STATE<br>19 MA.                |  |
| MILEAGE TO NEAREST TOWN<br>20 1.0  |  | DIVISION<br>21 ALBANY SERVICE          |  | INCIDENT DATE<br>22 06/13/01                         |  | INCIDENT TIME<br>23 5:00                |  |
| WEATHER<br>24 [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]  |  | NATURE OF COMPLAINT<br>25 LOWER BACK   |  | VISIBILITY<br>26 [ ] All [ ] Day [ ] Night           |  | [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] |  |
| WAS MEDICAL TREATMENT PROVIDED?<br>27 YES [ ] NO [ ]   |  |  |  |  |  |   |  |
| INTERNAL MEDICINE<br>377 WALNUT ST. EXT. PO BOX 788<br>AGAWAM, MA. 01001   |  |  |  |  |  |   |  |
| WAS PRESCRIPTION MEDICATION INCLUDED IN TREATMENT? [ ] YES [ ] NO  |  |  |  |  |  |   |  |
| I HAD JUST COMPLETED AN INSPECTION FROM MP127-74. WHEN I WAS LIFTING LEFT FRONT HY-RAIL WHEEL WITH BAR, THE GEAR ASSEMBLY BROKE TO RAISE WHEEL I HAD TO USE A LIFTING BAR AS A LEVER. THEN BROKE WHEEL WITH 4" WOOD BLOCK AT SAME TIME. WHEN I REACHED DOWN W/ BLOCK I FELT SOMETHING SNAP IN MY LOWER BACK. |  |  |  |  |  |   |  |
| IS THIS AN EMERGENCY?<br>28 YES [ ] NO [ ]   |  |  |  |  |  |   |  |
| WILL INCIDENT RESULT IN COST TO COMPANY?<br>29 YES [ ] NO [ ]  |  |  |  |  |  |   |  |
| WAS ANYONE AT FAULT?<br>30 YES [ ] NO [ ]  |  |  |  |  |  |   |  |
| DID DEFECTIVE TOOL OR EQUIPMENT CAUSE INCIDENT?<br>31 YES [ ] NO [ ]   |  |  |  |  |  |   |  |
| 32 YES [ ] NO [ ]  |  |  |  |  |  |   |  |
| HY-RAIL MECHANISM  |  |  |  |  |  |   |  |

JUN 25 '01 06:20

NOV 29 '01 09:30 FR

904 359 3175 TO 02456675

P.02/03

001 201 2001 00.00 010-2406553

DE OFFICE

PAGE 02

## ADDITIONAL SPACE FOR REPORT INFORMATION

DID EMPLOYEES HAVE A SAFE PLACE IN WHICH TO WORK?

31 ☒ Yes ☐ No If No, Describe Unsafe Working Conditions

WAS THE WORKPLACE ADEQUATELY LIGHTED?

32 ☒ Yes ☐ No If No, Describe Conditions

WAS THERE ANY FAILURE TO GIVE INITIAL OR NECESSARY SIGNALS, WARNINGS OR PROTECTION?

33 ☒ Yes ☐ No

IF ON-TRACK EQUIPMENT WAS INVOLVED, GIVE INITIALS AND NOS.

34 TC 500285

LOCATION WHERE EMPLOYEE NORMALLY REPORTS

NAME OF FACILITY WEST SPRINGFIELD YD.35 STREET VIA WESTERN AVE.CITY W. SPRINGFIELDSTATE MA. ZIP 01089

NAMES AND ADDRESSES OF WITNESSES TO THE INCIDENT

36 EMPLOYEE SIGNATURE

Paul T. Leporello

DATE

6/15/01

WITNESS TO EMPLOYEE SIGNATURE

38

NAME OF SUPERVISOR NOTIFIED

40

## MEDICAL INFORMATION RELEASE

I hereby authorize the release of all medical information reports and other medical data by any doctor, hospital, examiner or other health care provider relative to this injury(ies) sustained in this accident to the Chief Medical Officer and any other appropriate officer or representative of CSX TRANSPORTATION. A photocopy of this authorization is as valid as the original.

United Healthcare # 024000

SPECIAL TYPE OF MEDICAL COVERAGE IDENTIFIED ON YOUR INSURANCE CARD

Paul T. Leporello  
SIGNATURE OF EMPLOYEE

6/15/01  
DATE

IF YOU DO NOT WISH CSX TO PAY THE TOTAL AMOUNT OF ANY MEDICAL BILLS RELATED TO THIS INJURY, PLEASE "CAREFULLY" READ THE FOLLOWING PAGE.